

Colorado
Department
of Public
Health and
Environment

Reimbursement Efforts to Address Depression Among Pregnant and Postpartum Women



*A Supplement to the Nationwide Initiatives on
Pregnancy-Related Depression*



Colorado Department
of Public Health
and Environment

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Introduction

Overview of the Issue

Pregnancy-related depression, also known as maternal, postpartum or perinatal depression, occurs during pregnancy or as much as one year after giving birth, including after a pregnancy loss. In Colorado, more than one in every 10 women who give birth (10.5 percent) will experience signs and symptoms of depression (PRAMS, 2009-2011). ***This makes depression the most common complication of pregnancy.*** A wide body of research has shown that pregnancy-related depression can severely impact the health of both the mother and child, and may disrupt the mother-infant bonding period crucial to the child's future development. In addition, children of depressed mothers are more likely to exhibit social and emotional problems; delays or impairments in cognitive, linguistic, and social interactions; poor self-control; aggression; poor peer relationships; and difficulty in school.

Colorado's Work

Colorado's 2011-15 Maternal and Child Health Block Grant needs assessment identified pregnancy-related depression as one of nine priority areas for Colorado's Maternal and Child Health program at the Colorado Department of Public Health and Environment. Pregnancy-related depression is also a component of the department's mental health and substance abuse "winnable battle," which is one of 10 public and environmental health priority areas to improve the health of Coloradans. The Maternal Wellness team at the department is responsible for coordinating the state's pregnancy-related depression efforts. In this role, the team identifies and implements population-based approaches that promote timely screening, referral and support for pregnancy-related depression through improvements to the health care, mental health and community resource systems.

Nationally, in response to research on pregnancy-related depression, several states have moved toward a comprehensive approach to address screening, referral and treatment barriers, and the associated stigma. Some states are reimbursing Medicaid providers who assess for depression during pregnancy and the postpartum period using a validated screening tool. In order to learn more about potential Medicaid reimbursement strategies, the Maternal Wellness team identified states through a preliminary nationwide survey and interview process of state strategies for addressing pregnancy-related depression. Then the team conducted interviews with key informants from four identified states to gain more in-depth knowledge about the processes, benefits and challenges involved in implementing reimbursement for depression screening. A list of key informant interviewees can be found in Appendix A.

Methodology

During February and March 2013, the Maternal Wellness team conducted key informant interviews with representatives of states with unique Medicaid models for reimbursing assessment and screening for pregnancy-related depression and other behavioral health risks. States were selected based on prior key informant interviews conducted nationwide with state health department representatives to identify key successes and challenges with implementing

pregnancy-related depression efforts. Key informants were solicited through email for participation. All interviews were conducted by phone and recorded for reference.

An interview guide was created through a collaborative process with the Maternal Wellness team and the Epidemiology, Planning and Evaluation (EPE) Branch to determine the most important questions to ask about the state's processes, partners and implementation of its Medicaid model. An assessment of interviews was done using notes taken during interviews and audio recordings. Themes were compiled and reviewed by the EPE evaluator.

Results

Overview of Individual State Models

Interviews were successfully completed with Louisiana, North Dakota, Oklahoma and Virginia. Each of the interviewed states supports screening and assessment for depression during the pregnant and/or postpartum period using diverse models.

Louisiana provides reimbursement for the Louisiana Health Assessment, Referral and Treatment (LaHART) screening tool, an electronic assessment that addresses substance use, tobacco cessation and intimate partner violence. The state did not initially address mental health as part of the assessment due to limited capacity for referral and treatment options. Louisiana intends to re-address depression on the LaHART tool and is considering the Edinburgh Postnatal Depression Scale (EPDS) and other validated tools to determine which may be most easily integrated into the assessment's structure. Providers can be reimbursed \$14.49 for completing the assessment and an additional \$33.81 for 15-30 minutes of brief intervention counseling completed. Reimbursement for screening and brief intervention may occur once per pregnancy.

North Dakota reimburses for a maternal depression screening under the child's Medicaid identification number as a risk assessment for the child. The EPDS, Patient Health Questionnaire-9 (PHQ-9) or Beck Depression Inventory may be used. Providers receive a reimbursement rate of \$14.38 when the maternal depression screening is done in conjunction with a pediatric visit. Providers may receive up to three maternal depression screening reimbursements from birth through the child's first birthday.

Oklahoma has implemented the Prenatal Psychosocial Assessment Form, which provides a comprehensive look at the mental, physical and social state of a pregnant woman. The state used questions from the Problem Oriented Perinatal Risk Assessment System (POPRAS) to address mental health status on the Prenatal Psychosocial Assessment Form. The tool is designed in two parts, with the initial questions intended for completion by the patient alone and secondary questions structured for the provider to ask as part of a conversation. The provider converses with the patient about the mental health component. Providers can receive a reimbursement rate of \$30 when the Prenatal Psychosocial Assessment Form and the American College of Obstetricians and Gynecologists Medical History Form (or the equivalent) are done in conjunction with each other. Providers may bill for one assessment per patient per pregnancy, and patients may receive a maximum of two assessments throughout the pregnancy period, in the event the patient switches providers.

Virginia provides reimbursement for the Behavioral Health Risks Screening Tool developed for pregnant and non-pregnant women of childbearing age. This assessment includes questions focused on substance and alcohol use, tobacco use, intimate partner violence and mental health. The Edinburgh Postnatal Depression Anxiety Subscale (a three question screen) is used to address depressive symptoms and risk for co-occurring anxiety. If a pregnant or postpartum patient screens positive on this subscale, the full 10-question EPDS is used. Non-pregnant women are followed up using the PHQ-9. Providers may receive a reimbursement rate of \$7.69 - \$8.21, dependent upon whether the patient is under 21 years of age. Providers may bill during pregnancy and through the child's second birthday under the child's Medicaid identification number, with a limit of four units per pregnant member per provider and an additional four units per infant per provider per year.

Notable Trends and Strategies

Leveraging Existing Opportunities and Champions to Support Implementation

Key informants spoke of the need to identify champions who could support implementation of state models. External opportunities and champions were often facilitators used to establish the models and identify, or develop, screening and assessment tools. In North Dakota, a physician champion involved in the state's medical home pilot project approached North Dakota Medicaid about opening a maternal depression screening code. The physician's advocacy prompted North Dakota Medicaid to research the option and learn more about reimbursing providers for maternal depression screening. Based on that research, North Dakota Medicaid replicated Minnesota's process for reimbursement, which enabled providers to bill the child's Medicaid for the screening.

In Oklahoma, the priority to address psychosocial needs of pregnant women was championed by the Perinatal Advisory Task Force, a state level advisory group comprised of physicians and other organizations focused on serving pregnant women. This group was initially brought together to provide guidance on how to make systematic modifications to improve perinatal outcomes in the state. The task force identified gaps in coverage for pregnant women, which resulted in Oklahoma Medicaid developing a package of benefits for pregnant women that included the psychosocial assessment. The Prenatal Psychosocial Assessment Form was developed as a way to encourage providers to address their patients' psychosocial needs.

Additionally, many states noted success in implementation of screening reimbursement through leveraging other relevant opportunities, including funding sources and new federal requirements. In Virginia, state officials leveraged state legislation passed in 2008, which allows for reimbursement of substance abuse screening tools. In addition, Virginia leveraged tobacco screening requirements outlined by the Affordable Care Act (ACA), which requires providers to screen all pregnant women for tobacco use and provide tobacco cessation counseling. By implementing a combined screening tool, the state leveraged the other sources of funding and requirements to provide reimbursement coverage for depression. Additionally, Virginia's inclusion of intimate partner violence questions on the Behavioral Health Risks Screening Tool has enabled providers to meet one of the U.S. Preventive Services Task Force (USPTF) B Recommendations to screen all women of childbearing age for domestic violence.

In **Louisiana**, state officials leveraged Screening, Brief Intervention and Referral to Treatment (SBIRT) funding for reimbursement of the screening tool because LaHART includes substance use screening and referrals for treatment services. Additionally, Louisiana leveraged the ACA tobacco screening requirement by using the Louisiana Health Assessment, Referral and Treatment Screening Tool, which includes tobacco screening questions, as well as other risk factors for pregnant women.

Promotion of Depression Screening and Assessment

Across all interviewed states, communication to providers about the screening tools and Medicaid billing codes was necessary for successful promotion, uptake and continued use. In **North Dakota**, the maternal depression screening code is promoted in postings on the state's website in conjunction with lists of coding guidelines. The state also promotes the reimbursement opportunity through Regional Health Tracks Coordinators (the state's Early and Periodic Screening, Diagnostic and Treatment Program) and through North Dakota Medicaid's provider bulletin and newsletter.

Provider trainings also are a common method to promote the tools and billing codes. In **Oklahoma**, information about the Prenatal Psychosocial Assessment Form and billing information is included as part of a larger provider training on perinatal health services conducted by Oklahoma State Department of Health Maternal and Child Health social workers. In **Louisiana**, the most successful promotion efforts of LaHART include in-person visits to clinics to inform providers the tool exists. During these visits, trainers provide information on how to implement the screening and conduct brief intervention and counseling; assist with billing the code; help practices think through clinic flow; and help identify how to use the tool to refer patients.

Virginia also has conducted provider trainings so providers know what to do when a patient screens positive on the Behavioral Health Risks Screening Tool. In the past, Virginia Medicaid collaborated with the University of Virginia to provide training to practitioners about the impact of intimate partner violence, substance use, and depression among pregnant women and women of childbearing age. As part of the training, Virginia Medicaid provided information to practitioners on how to bill Medicaid for use of the Behavioral Health Risks Screening Tool, as well as what treatment services are available to women who screen positive. Practitioners received continuing medical education (CME) credits for participating.

Addressing Positive Screens and Providing Follow-up Services

Each of the interviewed states recognized the barriers associated with referral for, and access to, treatment services for women who screen positive for behavioral or mental health risks. Providers do not have the capacity or time to offer intervention services and there is often a lack of available services to refer to for appropriate follow-up. In response to this barrier, many states have established programs to respond to positive screening results.

In **Oklahoma**, around the same time that Oklahoma Health Care Authority's program, SoonerCare, was promoting the Prenatal Psychosocial Assessment Form; the agency developed the Maternal and Infant Health Social Work Benefit. This benefit enables licensed clinical social workers (LCSWs) to directly contract with Oklahoma Medicaid as SoonerCare providers and bill for services to address psychosocial concerns of pregnant women. These specialists can bill for as many as six sessions during pregnancy and as long as 60 days post partum using codes 96150, 96152 and 96154 for assessment and follow up. Obstetric care providers can refer to a

list of licensed clinical social workers on the Prenatal Psychosocial Assessment Form without needing a formal referral through Medicaid. In order for LCSWs to maintain a presence on the list they must submit annual proof that they are trained in maternal and infant mental health. This proof is submitted to a social worker at Oklahoma Medicaid for review and approval and can include conferences, continuing education classes or other educational opportunities.

Although this benefit provides a referral option, Oklahoma Medicaid has encountered capacity barriers, especially in rural communities, resulting from lack of access to licensed clinical social workers specifically trained in maternal and infant health. To help address this gap, Oklahoma Medicaid has encouraged coordination between licensed clinical social workers and obstetric care providers by suggesting that social workers offer their services within the obstetric practices to limit client transportation and access barriers.

In **Virginia**, if there is a positive screen using the Behavioral Health Risks Screening Tool, patients can receive additional services, including case management support during pregnancy and through the child's second birthday. As part of these programs, nurses at the health department conduct home visits and are reimbursed for these services. Through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, a licensed clinical social worker has been hired to conduct research on the use of the Behavioral Health Risks Screening Tool among home visitors.

In **Louisiana**, LaHART includes referral pathways integrated into a web-based system that meets the needs of providers and patients. However, Louisiana recognizes that providers are in need of additional referrals for mental and behavioral health services for patients. Although there are many Medicaid behavioral health providers in Louisiana, they do not always accept pregnant women or have the capacity to accept new patients. Cross-collaboration between primary health and behavioral health providers is necessary for this specialized population of pregnant women to access the appropriate level of treatment and behavioral health resources.

Notable Challenges

Making the Case to Expand Reimbursement

In order to assess the impact of reimbursing for screening on state budgets, some interviewed states conducted budget analyses. For example, **Oklahoma** completed a budget impact statement and analysis that included data comparing birth numbers, complications and birth outcomes to state costs for care. This information was used to make the case that developing a package of benefits, including a psychosocial assessment, for pregnant women would improve birth outcomes and save the state money.

While **Virginia** did not complete a formal budget impact analysis, the state did need to develop decision briefs for Virginia Medicaid administration approval. This brief included a justification outlining the pros and cons of expanding the reimbursement code to include screenings during the postpartum period under the child's Medicaid number. The primary justification used in Virginia's case was research indicating that identifying and addressing depression in the mother could prevent developmental delays of the infant. Since Medicaid is responsible for covering services needed by a developmentally delayed child, this justification presented a cost-savings opportunity for the state.

Data Collection

The ability to gather data regarding behavioral and psychosocial risks and other health outcomes of pregnant and postpartum women varied across the interviewed states. However, many noted the challenges associated with collecting behavior-specific data as well as tying claims data to health outcomes.

In **North Dakota**, Medicaid is unable to collect data on either the mother's mental health status or whether she completed a referral because the services are billed under the child's Medicaid identification number. In **Virginia**, the Medicaid office is unable to pull data on specific questions from the Behavioral Health Risks Screening Tool to determine whether the client screened positive for a specific health risk, such as depression or substance use. Virginia would have to complete chart reviews to determine specific risk behaviors and whether referrals were completed.

There has been noted success in **Oklahoma** regarding data collection. The state Medicaid office and the state health department coordinate a shared data work group that will create a large data set examining birth outcomes and data from several public health programs. Through this project, the work group created an annual data set dating back to the inception of the Oklahoma Medicaid benefits package and programs for pregnant women. The work group plans to analyze the data from this data set to evaluate programs for pregnant women, including the psychosocial assessment, and further examine birth outcomes in Oklahoma.

In **Louisiana**, the electronic reporting system for LaHART enables data collection and tracking on positive diagnoses. For example, data can be generated to determine how many women screen positive for substance use, tobacco use or domestic violence. Louisiana emphasizes the need to maintain the system because the state currently does not have quality data on prenatal substance use and treatment. By developing the screening tool as user-friendly and electronic, providers are more likely to use it and the state is able to access data to support the development of a behavioral health provider network in Louisiana.

Key Recommendations

As part of the interview process, representatives were asked to reflect on what they would recommend to a state that embarks on a similar process for implementation and coverage of pregnancy-related depression screening. Representatives agreed on the following:

- Recruit champions to support the efforts, including champions embedded within those agencies charged with making change, such as reimbursement agencies.
- Develop a universal screening tool that addresses multiple requirements and reimbursement opportunities mandated by the Affordable Care Act and other pertinent legislation. States that have successfully implemented a universal tool can provide a wealth of examples, including the opportunity to replicate their tools for future use.

- Develop strong relationships to ensure success in collaborative work. One representative recommended establishing business agreements between partners to explain how state agencies are expected to work together. This may be especially helpful when there is not legislation mandating collaboration.
- Explore options that allow providers to be reimbursed for longer office visits to account for the increased time needed to address multiple screening requirements. One state representative recommended exploring codes associated with Evaluation and Management Services as a means to account for longer office visits.

Conclusion

By implementing and reimbursing for various screening tools, the four interviewed states enabled Medicaid providers to assess the many needs of their patients, including behavioral health and psychosocial needs, substance and tobacco use, and intimate partner violence. By assessing these risks, providers have been able to provide referrals and treatment for their patients. Each of the states successfully implemented the tools with the support of champions and by leveraging external opportunities such as ACA funding.

These successes do not come without challenges. States interviewed continue to face barriers with regards to data collection and analysis, as well as the availability of follow-up services when there is a positive screen. Colorado faces these same challenges, and is increasingly in need of resources for women who screen positive for pregnancy-related depression. The state has the opportunity to reflect on the lessons learned and achievements made by those states that have successfully implemented reimbursement models for depression screening during pregnancy and the postpartum period and use them to inform potential future opportunities within Colorado Medicaid for reimbursement.

Appendix A: List of State Interview Participants

Louisiana Caroline Brazeel	Louisiana Birth Outcomes Initiative Office of the Secretary	Louisiana Department of Health & Hospitals
North Dakota Jodi Hulm	Medical Services	North Dakota Department of Human Services
Oklahoma Shelly Patterson	Director of Health Promotion & Community Relations	Oklahoma Health Care Authority (OHCA)
Virginia Ashley Harrell	Acting Manager Maternal and Child Health Division	Virginia Department of Medical Assistance Services